DEPARTMENT OF HEALTH & HUMAN SERVICES
DIVISION OF AGING AND ADULT SERVICES
PROVIDER AGENCY INFORMATION

1. TYPE OF INFORMATION Check (√) only one	2. DATE	3. REGION	4. PROVIDER CODE	5. CONTRACT YEAR
☐ 1 NEW ☐ 2 CHANGE				

6. AGENCY NAME	7. TELEPHONE __ __ __ - __ __ __ - __ __ __ __

8. AGENCY ADDRESS	9. FAX NUMBER (optional) __ __ __ - __ __ __ - __ __ __ __

CITY	STATE	ZIP CODE

9. CONTACT PERSON(S) FOR AGING SERICES

NAME	TITLE
NAME	TITLE
E-MAIL ADDRESS (optional)	WEB PAGE (optional)

10. TYPE AGENCY Check (√) all applicable		
	1	Non-Profit
	2	Profit
	3	Public
	4	*Minority

11. TYPE SERVICES PROVIDED Check (√) all applicable	
	Supportive
	Nutrition-Congregate
	Nutrition-Home Delivered

FOR NUTRITION PROVIDERS ONLY

12. Providers of Congregate Nutrition Service, only - indicate the number of facilities by type: |___| Senior Center |___| Operating School |___| Restaurant |___| Community Center |___| Religious |___| Public or Low Rent Housing |___| All Others

13. CONGREGATE - NUMBER OF DAYS SERVING						
7	6	5	4	3	2	1

14. Serving More than One (1) Meal Per Day	
Yes	No

15. HOME DELIVERED MEALS - NUMBER OF DAYS DELIVERING						
7	6	5	4	3	2	1

16. Serving More than One (1) Meal Per Day	
Yes	No

*Minority Provider - An organization or business concern that is (a) is at least 51 percent owned by one or more individuals who are either an African American, Hispanic origin, American Indian/Native Alaskan/Native Hawaiian, Asian American/Pacific Islander minority or a publicly owned business having at least 51 percent of its stock owned by one or more minority individuals (or is governed by a board consisting of at least 51% minority individuals in the case of a private non-profit) and (b) has its management and daily business controlled by one or more minority individuals.

NOTE: This form is not applicable to subcontractors of provider agencies

DOA-150 (Rev. 12/17/2004) ROUTING: White Copy-DOA; Canary Copy-AAA; Pink Copy-Provider File

Department of Health and Human Services
NC DIVISION OF AGING AND ADULT SERVICES
Aging Resources Management System (ARMS)

FORMS INSTRUCTIONS

PROVIDER AGENCY INFORMATION DOA-150

A. PURPOSE

    Provider Agency information is collected each year for entry in the ARMS system in order that Provider budget information may be entered in the ARMS system and in order that unit and reimbursement information may be correctly processed.

B. GENERAL INSTRUCTIONS

    1. This form is completed each fiscal year by the aging service providers or Department of Social Services (DSS) providing services under Option B. The local service provider must have a contract with the AAA. This form is not applicable to subcontractors.

    2. All forms must be received at the Division of Aging for the upcoming fiscal year. The Division of Aging will enter the information in the ARMS system.

    3. A DSS should send the white and canary copies of the form to the Division of Aging and maintain the pink copy for their files if they are providing services under Option B.

    4. The form should be completed with a blue ball point pen.

C. SPECIFIC INSTRUCTIONS FOR EACH ITEM

    1. TYPE OF INFORMATION: Indicate what action is being taken with this form. Check one item only. REQUIRED

        a. New - Check this item the first time this form is completed each contract year

        b. Change - Check this item when information which was previously submitted in the same contract year is being changed

    2. DATE: Enter the date the form is being completed. Enter a two (2) digit number to reflect the month and days. Precede one (1) digit months and days with a zero (0). Enter the last two (2) digits of the year. REQUIRED

    3. REGION: Enter the one (1) digit alpha or numeric character which identifies the region. REQUIRED

    4. PROVIDER CODE: Leave the two (2) digit Provider Code field blank when submitting new information. The State MIS Coordinator will assign a provider code. A provider code for a DSS will be identical to the county code. REQUIRED

    5. CONTRACT YEAR: Enter the last two (2) digits of the fiscal year. The entry for fiscal year 1995-96 would be 96. REQUIRED

    6. AGENCY NAME: Enter the complete Agency Name. Spaces and dashes are allowed. If adequate spaces are not available, enter as much of the name as possible. Enter no more than one (1) letter per space. REQUIRED for new forms.

7. TELEPHONE: Enter the agency telephone number, include area code. REQUIRED for new forms.

8. AGENCY ADDRESS: Enter the Agency's mailing address. Spaces and dashes are allowed. If adequate spaces are not available, enter as much of the address as possible. Enter no more than one (1) letter per space. Address, City, State, and the first five (5) digits of the zip code are REQUIRED for new forms.

9. CONTACT PERSON(S): Enter the first and last name and title of an agency contact person whom the state office can contact regarding the program. At least one contact person's name and title is REQUIRED for new forms.

10. TYPE AGENCY: Check the type of agency which is applicable (Non-Profit, Profit, or Public) Also check Minority if applicable. Check all that are applicable. Those not applicable should be left blank.

11. TYPE SERVICES PROVIDED: Check all types of services provided by the agency which are funded by DOA administered funds. This item is REQUIRED for new entries. If your agency provides supportive services only, do not complete the remainder of the form.

12. NUMBER OF FACILITIES BY TYPE: The Number of Facilities by Type for providers of Congregate Nutrition ONLY. Indicate the number of facilities your agency operates by type. Those not applicable should be left blank. At least one (1) type must have a number greater than zero (0).

13. CONGREGATE - NUMBER OF DAYS SERVING: REQUIRED entry on new forms for providers of Congregate Nutrition. Indicate the number of days per-week the agency provides meals.

14. SERVING MORE THAN ONE MEAL PER DAY: Indicate whether the agency serves more than one (1) meal per-day. Check yes if the agency habitually serves more than one (1) meal per-day and no if it does not. This is a REQUIRED entry on new forms for providers of Congregate Nutrition.

15. HOME DELIVERED MEALS - NUMBER OF DAYS DELIVERING: Indicate the number of days the agency normally provides Home Delivered Meals per-week. REQUIRED entry on new forms for Providers of Home Delivered Meals.

16. DELIVERING MORE THAN ONE MEAL PER DAY: Indicate if more than one (1) Home Delivered Meal is delivered per day per person by checking yes or no. REQUIRED entry on new forms for providers of Home Delivered Nutrition.